CORRESPONDENCE

Problems with private pathology practice

I have read the article entitled 'Why I don't believe in referral commissions' by Arun Sheth (1). What struck me as odd about this piece was the fact that we now need to justify the 'right thing to do'. The very fact that doctors who don't give or take 'cuts' are a minority nowadays speaks badly enough of our 'noble' profession. But that we now need to find reasons and justifications for doing the proper things is truly a serious cause for introspection. It appears that a wrong done over and over again by a large number of people, and highly educated people at that, soon becomes the order of the day. Hence, doctors who 'don't fall in line' risk greater marginalisation from the mainstream. They take too long to establish themselves and some finally just give up and change professions. This is especially true for people like us who have dependent practices like pathology.

Let's look at some facts in the pathology 'business'. Technician-run laboratories are prepared to go to any lengths to secure their 'business'. Although it is degrading for qualified pathologists to compete with technicians, there is no other way because even top consultants accept these reports (sometimes even unsigned ones) from technicians. We even have a few technicians requesting us to report their peripheral smears or cytologies or even biopsies which means that even these investigations are sent to technicians' labs and not to pathologists. The flip side is that when it comes to the consultant's own relatives or friends they always come to a pathologist even for the simplest of tests. What's good enough for other patients is not so for the doctor's kith and kin.

Consortium-owned labs or group practice set-ups are the 'in' thing. Here, doctors invest money together in a diagnostic set-up and then send long lists of investigations for kickbacks and incentives. (From the layperson's point of view this is viewed as hunting in packs.) I think the main issue here is the percentage receivable, rather than what is necessary for the patient. It is one thing to make a project viable, quite another to burden the patient for your personal gain.

Then comes the choice of the patient to go to any lab. Due to the nexus that exists between the clinics and labs, unless a patient comes back with a report from a particular lab, he is subjected to another battery of tests with the explanation, 'These tests are wrong; why didn't you go to the other lab?' The poor patient fears the wrath of the doctor and does as he is told, in the process compromising his right to choose where he wants to go.

I have even heard of places where *rickshawallahs* and drugstore owners are roped in to direct patients. This absolutely unethical way of 'soliciting clients' just proves to what lengths we are now ready to go to succeed in our profession. It is even more depressing to think how the big reference labs have affected small private set-ups like mine to compete with their prices, especially when nobody cares about the quality of reports that these labs have to offer.

Thus, it is becoming very difficult to practise pathology in a clean manner. It is the patient who is being taken for granted all the time. I have managed so far to keep myself away from these practices but always get an 'explanation' from my male colleagues that it's because I am a woman and don't have to 'support' a family. I think we must take steps to create a space for ethical doctors to be able to earn a living while practising their professions with dignity and self-respect. In this, I feel the National Accreditation Body for Laboratories must play an important role and laboratories must be licensed and accredited.

Meanwhile, to those who wish to practise market-medicine, I wish you much happiness in your endeavours. But remember what Gibbon said: 'The first and indispensable requisite of happiness is a clear conscience, unsullied by the reproach or remembrance of an unworthy action.'

Reference

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Audits of electroconvulsive therapy

Waikar et al. (1), in their diatribe against ECT (electroconvulsive therapy) in general, and unmodified or direct ECT in particular, were shocked that our institutional ethics committee permitted an 11-year 'study' of unmodified ECT (2), where patients whose 'fearful refusal of a hazardous and life-threatening procedure' were 'considered as a mere symptom of insanity, and further treated with sedatives'. They were appalled that ECT was given to children, elderly and pregnant women. They contend that our report trivialised the 'horrific' physical complications with direct ECT and 'the costs of disability days following ECT'. They wonder 'why presumably rational scientists produce such irrational arguments to safeguard a scientifically dubious and highly hazardous procedure', concluding that it is because we 'make a lot of money by giving ECT'.

ECT is an invasive procedure, like neurosurgery, and considerations of morbidity or mortality must therefore be viewed in this context. Untreated or treatment refractory mental illness kills and wastes precious lives. There is incontrovertible evidence that ECT is an effective treatment for depression (3), and substantial evidence that it is effective in mania (4) and schizophrenia (5), especially when other treatments fail. There is no credible evidence that ECT causes brain damage (6). ECT is not contraindicated, and may be especially effective, in pregnant women, children or the elderly (7).

Ours was not a prospective research study but a retrospective chart audit of clinical practice (2). Over 11 years, 6.3% of the 28,929 patients registered at our centre were treated with ECT, hardly the overenthusiastic and indiscriminate use implied by Waikar et al. (1). Of the 13,597 individual treatments given to 1,835 patients, the physical morbidity included spinal compression fractures and transient myalgia in less than 1%, resulting in short-lived pain but no disability, neurological deficits or long-term sequelae over up to 8 years follow-up. One patient died (mortality rate 0.05%) of a cardiac arrhythmia, though the subsequent 12 years and approximately 2,000 additional patients treated have not seen additional mortality.

In spite of this low complication rate for an invasive procedure, all treatment conducted here since 1995 have been modified under anaesthetic supervision, and our practice, frequently audited, conforms to the international technical and ethical standards. No patient has ever received ECT without personally (or a responsible relative) consenting. Fear of ECT is less with modified than with unmodified ECT but in both situations an unknown and reputedly hazardous procedure does generate apprehension, just as with tooth extraction or brain surgery. Pre-ECT sedation reduces apprehension. ECT, as practised in our centre, is hardly a lucrative enterprise since costs are low (Rs 180 per modified treatment, excluding anaesthetic drug costs) and many patients' treatments are free or heavily subsidised. Finally, our patients and their relatives have endorsed our use of ECT (8).

Unmodified ECT is aesthetically less appealing to patients and clinicians alike than modified ECT. Consideration of ways to phase out direct ECT such as changing from thrice a week to the equally effective twice a week regimen to reduce anaesthetist demand, or forming group practices with shared ECT and anaesthetic facilities, or deputing psychiatric personnel to get specialist anaesthetic training are inevitable, if ECT is to survive another 50 years. However, banning direct ECT overnight by legal action without ensuring the continued and effective delivery of ECT is tantamount to closing down mental hospitals without ensuring adequate community care. Many clinicians, without access to anaesthetists, would face denying seriously mentally ill patients an effective treatment. Such a 'collateral damage' resulting from well-intentioned action is as unethical and unacceptable as some recent international events.

References

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Unmodified ECT vs modified ECT

This letter refers to the article by Chittaranjan Andrade regarding the use of unmodified ECT (1). The author has discussed the obvious advantages of modified ECT over unmodified ECT. He also highlights the ground realities and difficulties in practice of modified ECT. The author concludes that the use of unmodified ECT may be preferable to no ECT, as in the case when ECT is indicated but anaesthesiological facilities are unavailable or unaffordable.

Though I agree in principle with the points raised and this discussion may be scientifically correct, we need to know the views of the people who are going to be recipients of such treatment. It has been seen that doctors show remarkably little interest in their patients' views of the procedure and its effects on them (2). I think that in this discussion on the ethical issues of administering unmodified ECT, a patient's perspective is not being considered. Though no data are available, most of the patients who refuse ECT do so because of the fear associated with the procedure. This fear may be attributed to the gruesome and barbaric picture of ECT projected by the media in which patients are shown screaming and refusing ECT and later on convulsing.